DOCUMENT RESUME

ED 422 545 CG 028 634

AUTHOR Horvatich, Paula K.; Wergin, Jon F.
TITLE Building a New Profession: Defining and Measuring the Competence of Addiction Counselors.
PUB DATE 1998-04-00
NOTE 33p.; Paper presented at the Annual Meeting of the American Educational Research Association (San Diego, CA, April 13-17, 1998).
PUB TYPE Reports - Research (143) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Counselor Certification; *Counselor Qualifications; *Counselor Training; Higher Education; National Surveys; Standards; *Substance Abuse; Tables (Data)

ABSTRACT

The education of addiction counselors, once based on tradition, myth and politics, is becoming professionalized, based on competencies, research and best practice. Many factors have contributed to this shift as subspecialties for addiction treatment have emerged in various disciplines. In 1993 the Center for Substance Abuse Treatment created the Addiction Technology Transfer Center Program to foster improvements in the preparation of treatment professionals. A curriculum committee developed a set of 121 competencies for practice. A survey was conducted to validate the competencies, determine gaps between actual and needed competencies displayed by entry-level counselors, and determine congruence among the perceptions of three practitioner groups: clinical supervisors, least experienced counselors, and most proficient counselors. Results for demographics, data reduction procedures, validation of the 121 competencies, gaps between actual and needed competencies, congruence among perceptions of counselor groups, and competency subsets are reported. Large gaps were observed between what competencies counselors need to do the job and the competencies they possess. Discussion includes validation issues, the further usefulness of the survey findings, and the competencies list. Tables present demographics and needs assessment; the complete "Addiction Counselor Competencies" document developed by the committee is appended. (EMK)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

P. HORVATICH

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

ED 422 545

Building a New Profession:
Defining and Measuring the Competence of Addiction Counselors

A Paper Presented at the
American Educational Research Association Annual Meeting
April 13-17, 1998, San Diego, California

Paula K. Horvatich and Jon F. Wergin
Virginia Commonwealth University

Introduction:

The education of addiction counselors, once based on tradition, myth and politics is becoming professionalized, based more on competencies, research and best practice (Fisher, 1997). Treatment for psychoactive substance abuse and dependence has traditionally been provided by addiction counselors; while many have academic degrees, many others have become counselors following personal experiences with treatment and recovery (Deitch and Carleton, 1997). Formal education for addiction counselors has usually consisted of specialty training provided by treatment agencies, rather than by academic institutions. Certification of addiction counselors varies from state to state, but usually requires a high school diploma and a specified number of years of experience in the field. Only recently has a bachelor's degree been required, and only in some states. In others, addiction counselors do not need to be certified at all, as long as they work in a state-approved facility.

Due to a variety of policy and economic factors, training requirements for certification in addiction counseling have become more rigorous. These factors include, among others, the pervasiveness and impact of substance abuse on society, expanded treatment research efforts, and managed behavioral health care. If substance abuse problems were not so pervasive and damaging to society, there would be little interest in the credentials of addiction counselors and the outcomes of the treatment they provide. Although treatment research has grown rapidly and has provided useful insights, new information will be useless unless it is implemented by front-line practitioners. These counselors must be able to understand and apply new knowledge; but traditionally these connections have not been made (Fisher, 1997).

Efforts to make treatment more efficient have resulted in the integration of substance abuse with mental health services, thereby increasing the role of mental and other health care professionals in substance abuse treatment. Addiction specialities have emerged in medicine, nursing, social work, psychology and counseling, including rehabilitation counseling. Managed care has made it increasingly likely that only master's level addiction counselors will be reimbursed for services provided. Addiction counselors who are currently "certified" with only a high school diploma will certainly have difficulty making this leap to a master's degree. Many addiction counselors will not be able to obtain the advanced education needed fast enough to survive in the market.

CG028634

In 1993 the Center for Substance Abuse Treatment created the Addiction Technology Transfer Center (ATTC) Program to foster improvements in the preparation of addiction treatment professionals (Rohrer et al., 1996). As part of the ATTC Program, a National Curriculum Committee (hereafter called the "Committee") was established to evaluate existing curricula and to set priorities for current academic programs. At its first meeting, the Committee realized that the field had not defined the knowledge, skills and attitudes that should be shared by all addictions counselors. Identifying and delineating these competencies became the Committee's first task in an effort to professionalize the field.

The Committee approached its work using a modified DACUM (Develop a Curriculum) process (Norton, 1985). The Committee, consisting of 13 expert professionals representing the range of specialities within the field, provided practice-related information through a brainstorming process. Once the general responsibilities of the field were identified, the Committee developed task statements for each. Committee members ordered the responsibilities and task statements in a learning sequence, based on which responsibilities are generally performed first on the job. The process of identifying responsibilities was considered complete when the Committee reached consensus regarding the accuracy and sequence of the task statements produced. Typically, a DACUM process results in 8-12 responsibilities and 50-200 tasks. The Committee identified four transdisciplinary foundations and eight practice dimensions encompassing 121 competencies. The four "Foundation" categories were Understanding Addiction, Treatment Knowledge, Application to Practice, and Professional Readiness. The eight "Practice" categories were Clinical Evaluation, Treatment Planning, Referral, Case Management, Counseling, Client, Family, and Community Education, Documentation, and Professional and Ethical Responsibilities. Each category had between three and twenty competencies in it.

This effort resulted in the 1995 publication of *Addiction Counselor Competencies* (Appendix A).

Although the Committee incorporated existing literature related to the work of addiction counselors, particularly the practice analysis conducted by Birch and Davis (1986) and the ICRC Role Delineation Study (1991) when developing the *Competencies*, it relied more on its own original contributions. The Committee felt that job-related data provided a snapshot of what is, not what could be. And in the addiction counseling field, *what is* has been under criticism. Due to its peer counselor and personal experience history, treatment provided by some addiction counselors has been criticized as narrow and inflexible, resulting in an inability or unwillingness to adopt alternative treatment methods to meet the individual needs of clients. Moreover, the field's history of limited educational preparation has resulted in counselors who are unable to understand and incorporate new research-based treatment methods, even if they wanted to. Consequently, the Committee relied on its own expertise to move the field forward. Because the *Competencies* were not developed in collaboration with practitioners in the field, the *Committee* conducted a survey to determine which of 121 competencies were also perceived as necessary for practice by addiction counselors in the field.

Method:

The purposes of this study were to: validate a set of 121 competencies for the profession of addiction counseling; determine gaps between actual and needed competencies displayed by entry level counselors; and determine congruence among the perceptions of three practitioner groups. The study was conducted in partnership with the ATTCs, CSAT and the Northwest Regional Educational Laboratory (Adams & Gallon, 1997).

A survey was conducted in sixteen states plus Puerto Rico during November, 1996 through January, 1997. The survey instrument was distributed through the ATTCs to state-approved substance abuse treatment agencies. State authorities worked with ATTCs to select qualified treatment sites, distribute the surveys with appropriate cover letters from the state authority, and implement follow-up strategies to ensure an adequate return rate.

A random sample of 60 state-approved treatment facilities was selected in each of the participating states. For states with fewer than 60 qualifying facilities, all state-approved treatment facilities were included in the study if the facility was large enough to have a separate clinical supervisor, who was not also an administrator in the facility.

Each treatment agency director was sent a cover letter and instructions, three copies of the 16-page survey listing 121 competencies and corresponding postage-paid return envelopes. Directors were asked to distribute the surveys to a *clinical supervisor*, a *least experienced counselor*, and a *most proficient counselor*. "Least experienced" was defined as non-supervisory direct-care counselors having up to three years of paid experience as an addiction treatment professional. Each of the three respondents rated the level of proficiency "typically demonstrated" by entry level counselors at the time of hire, as well as the level of competency "needed" at the time of hire. Each respondent was instructed to provide a rating for each item on a five-point-scale, ranging from 1 ("very little to no knowledge/ skill/ attitude"), to 5 ("excellent knowledge/ skill/attitude"). Beginning one week following the due date, telephone calls were placed with nonresponding agencies, encouraging them to submit finished surveys. Final response rates varied by state, ranging from 25% in North Carolina to 82% in Maryland; the response rate nationally was 46.3%. The total number of respondents was 1227.

Results:

Demographics. (See Tables 1-6.) Respondents included 365 least experienced counselors, 411 most proficient counselors and 451 clinical supervisors (n=1227). Females outnumbered males in all respondent groups. The sample was mostly middle-aged and age increased with level of experience. Seventy-five percent of the respondents were Caucasian, 14% African American, 7% Hispanic and 4% filled other minority categories or were undeclared.

The respondents were well educated with 74% reporting Bachelor's or Master's degrees. As expected, clinical supervisors reported the greatest number of graduate degrees. Clinical supervisors and most experienced counselors reported the longest employment in the field (i.e. greater than 5 years). Although "least experienced" was defined as less than three years paid experience, many "least experienced" counselors reported more than three years of employment in the addictions profession. This may be due to a mistaken inclusion of other experiences in the field such as volunteer service, internships or personal treatment and recovery. The least experienced counselors had the smallest proportion certified, while clinical supervisors had the highest proportion certified.

Data reduction procedures. Given the huge number of possible cross-tabulations with a survey this size, results have been summarized in three different ways for this paper. First, since the purpose of the study was to identify "essential" competencies, survey responses were collapsed into percentages of respondents rating each item "4" or "5" ("good" or "excellent"). Excluding the "moderate" ratings provides a more stringent standard for judging the content validity of the competencies. Second, results are provided for the national sample only. Third, responses have been summarized across individual competencies within the twelve competency categories.

Validation of the 121 competencies. Internal consistency of the survey was high: Cronbach's Alpha for the twelve sections of the survey ranged from .91 to .98. Among the clinical supervisors, 40% of respondents indicated that entering practitioners needed to be "good" or "excellent" in *all 121* competencies; 60% gave these ratings for 118 of the 121 competencies; and 70% gave these ratings for 107 of the 121 competencies. Clearly, the surveyed competencies had high content validity for these experienced practitioners.

Gaps between actual and needed competencies. Large differences were found between perceived *needed* and *actual* proficiency, across all three respondent groups. As Table 7 indicates, the gap was most pronounced among clinical supervisors. For all but one of the 121 items less than half of the supervisors rated actual proficiencies as "good" or "excellent." Table 8 displays the percentage gaps for each of the twelve categories, for clinical supervisors only. Gaps between actual and needed proficiencies are evident across categories, ranging from a 44% gap for the "Referral" category to a 54% gap for the "Counseling" category. Just as the perceived need for counselor competencies was consistently high, the perceived level of *actual* competencies was consistently low.

Congruence among perceptions of counselor groups. As Table 1 indicates, while the three counselor groups are consistent with one another in their ratings of need, they differ consistently in their ratings of actual proficiency. In each category the lowest ratings were given by supervisors, followed by "most proficient" and then

"least experienced" counselors. Differences between supervisors and least experienced counselors were lowest in the "Treatment Planning" category and greatest – not surprisingly – in the "Professional Readiness" category.

Competency subsets. Ratings of some subsets of the competencies indicate a need for further study. For example, supervisors and counselors seemed to undervalue competencies related to research and treatment outcome assessment. It is interesting to note that these subsets did not appear in earlier published job performance analyses for addiction counselors. The Committee included these competencies because it felt that the counselors' abilities to assess and monitor outcomes and apply research findings to their own practice were important and would contribute to making the field more professional.

In sum, this survey revealed large and consistent gaps between actual and needed competencies across all categories, with clinical supervisors showing the largest differences.

Discussion:

Clinical supervisors, entry level and most proficient counselors endorsed almost all of the 121 competencies as important. However, the responses of each professional group also show relatively little discrimination among items and categories, which may account for the high Alpha coefficients. Given the large number of items in the survey, this level of consistency could indicate a substantial halo effect: that is, respondents could have been answering individual items on the basis of an overall impression, and chose not to make fine discriminations among the individual competencies.

The results also indicate large gaps between what is needed and observed in proficiency for entry level counselors, even among entry level counselors themselves. Supervisors noted the greatest gaps, followed by the most proficient and entry level counselors. Although the least experienced counselors reported the smallest gaps, the gaps were still substantial, indicating that what counselors know they *need* to do the job, and what they *can do* are two different things.

What accounts for supervisors' ratings of entry level proficiency being more critical than the other respondent groups? One possibility is a contrast effect. That is, supervisors may be using their own level of expertise as the standard for comparison resulting in unrealistically high expectations for entry level counselors. In this instance, counselors with average proficiency would receive lower ratings against the supervisors' higher, elevated standard representing significantly more experience.

As a content validation strategy the survey has limited value. Respondents were given 121 statements to respond to and little discrimination among the items was observed.

However, all the competencies were perceived to be important and the preparation for each was always reported as inadequate. Respondents appeared to address the list as a whole, and not the individual competencies. Those who would embark on curricular change should do the same. That is, formal preparation for addiction counselors cannot just be bolstered here and there; it needs to be completely rebuilt. In that sense the survey results have mostly political value, as a catalyst for curricular change.

This has already proven to be the case.

While the survey was being conducted, the Committee was already working on an expanded document that listed the knowledge, skills and attitudes for each of the 121 competencies (ACC:KSA). Feedback from the field was obtained on the draft document. Then in December, 1996, the International Certification and Reciprocity Consortium (ICRC) convened a national leadership group to deliberate the need for model addiction counselor training. After careful deliberation, the group concluded that the Committee and the ICRC had already completed most of the work based on their respective documents—the ACC:KSA and the Role Delineation Study (1996).

Soon after, the Center for Substance Abuse Treatment (CSAT) agreed to fund a collaborative effort to finalize the ACC:KSA and formed The National Steering committee for Addiction Counseling Standards (NSC). The NSC, consisting of representatives from five National educational, certification and professional associations, who had never collaborated before, were successful in achieving unanimous endorsement of the ACC:KSA—a historical milestone in the addiction counseling field. The ACC:KSA document was recently published by CSAT as its Technical Assistance Publication #21—*Addiction Counseling Competencies: The Knowledge, Skills and Attitudes for Professional Practice (TAP21).*

The significance of TAP21 for addiction counseling is that it provides a single frame of reference for curriculum development, student advising, professional development, and clinical supervision. The NSC continues to promote TAP21 and is using it to develop a scope of practice statement and practice guidelines to further professionalize the addiction counseling field.

Conclusions:

While this is a study of perceptions and professional judgment, and further inquiry is needed into the reasons for the discrepancies, these results do suggest that clinical supervisors are getting far less than they need in entry level counselors. More systematic discussions are needed between clinical practitioners and faculty of training programs in addiction counseling, from which should emerge a redefinition of curricular goals based on TAP21.

Addiction counseling is a profession in the making. In most states, up to the mid-90's, candidates could be certified as addiction counselors without a college degree. Rather than maintaining its professional culture by relying on tradition, addiction counseling is building its identify from the ground up, by first identifying competencies all addiction counselors are expected to possess. Such an approach addresses directly the "education-practice discontinuity" cited by Cavanaugh (1993) as one of the most critical problems in professional education.

Acknowledgments

This study was funded by the Health Services Administration's Center for Substance Abuse Treatment Grant Number 5U98 TI 00837.

References:

Adams, J. R., & Gallon, S. L. (1997). Entry Level Addiction Counselor Competency Survey: National Results. Portland, OR: Northwest Regional Educational Laboratory.

Addiction Technology Transfer Centers, National Curriculum Committee, Center for Substance Abuse Treatment. (1998). Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice. (Technical Assistance Publication No. 21). Rockville, MD: Author.

Addiction Technology Transfer Centers, National Curriculum Committee, Center for Substance Abuse Treatment. (1995). Addiction counselor competencies. Rockville, MD: Author.

Birch & Davis Corporation. (1986). Development of model professional standards for counselor credentialing. Dubuque, IO: Kendall/Hunt Publishing.

Cavanaugh, S. H. (1993). Connecting education and practice. In L. Curry & J. F. Wergin (Eds.), Educating professionals. San Francisco, CA: Jossey-Bass Inc.

Deitch, D. A., & Carleton, S. A. (1997). Education and training of clinical personnel. In J.H. Lowinson, P.Ruiz, R.B. Millman & J.G. Langrod (eds.), Substance abuse: A comprehensive textbook. Baltimore, MD: William & Wilkins.

Fisher, G. (1997, September). Training Issues for Addiction Counselors and Other Helping Professions. Paper presented at the meeting of the Mid-Atlantic Addiction Educator's Conference, Williamsburg, VA.

National Certification Reciprocity Consortium/ Alcohol and Other Drug Abuse. (1991). Role Delineation Study for Alcohol and Other Drug Abuse Counselors. Raleigh, NC: Author.

Norton, R. E. (1985). DACUM Handbook. Columbus, OH: Ohio State University National Center for Research in Vocational Education.

Rohrer, S. R., Diesenhaus, D. I., Jaffe, J. H., Morgan, E.T., & Kilpatrick, N. S. (1996). Addiction technology transfer centers (ATTCs). Subtance Abuse, 4, 193-199.

National Entry-Level Addiction Counselor Competency Survey
Demographics

Table 1. GENDER

	Supervisor	Most Proficient	Least Experienced	Total
Male	198	153	130	481
Female	259	259	239	757
Total	**457**	**412**	**369**	**1238**
missing:	n=14 (1.1%)			

Table 2. AGE

	Supervisor	Most Proficient	Least Experienced	Total
Under 21	0	0	1	1
21-29	19	30	72	121
30-39	104	112	106	322
40-49	194	169	118	481
50-59	115	79	53	247
60 and over	17	18	15	50
Total	**449**	**408**	**365**	**1222**
missing	n=30 (2.4%)			

Table 3 RACE/ETHNICITY

	Supervisor	Most Proficient	Least Experienced	Total
African American	60	56	57	173
Hispanic	28	32	31	91
White	345	305	262	912
Native American	5	8	5	18
Asian/Pacific Islander	3	1	2	6
Other	7	1	1	9
Undeclared	5	5	4	14
Total	**453**	**408**	**362**	**1223**
missing	n=29 (2.3%)			

Note: From Entry Level Addiction Counselor Competency Survey: National Results, by R. J. Adam and S. L. Gallon, 1997, Portland, OR: Northwest Regional Educational Laboratory.

Table 4. EDUCATION

	Supervisor	Most Proficient	Least Experienced	Total
GRE/High School Diploma	9	6	13	28
Some College or Technical/Trade School	50	65	70	185
Associate's Degree	23	49	37	109
Bachelor's Degree	112	130	135	377
Graduate Degree (Master's level and above)	257	161	110	528
Total	**451**	**411**	**365**	**1227**
missing	n=25 (2.0%)			

Table 5. PERIOD OF EMPLOYMENT IN THE ADDICTIONS PROFESSION

	Supervisor	Most Proficient	Least Experienced	Total
Less than 6 months	4	10	30	44
6 months to 18 months	13	17	78	108
19 months - 3 years	20	31	68	119
3 to 5 years	49	67	69	185
5 to 10 years	113	159	80	352
More than 10 years	251	126	40	417
Total	**450**	**410**	**365**	**1225**
missing	n=27 (2.2%)			

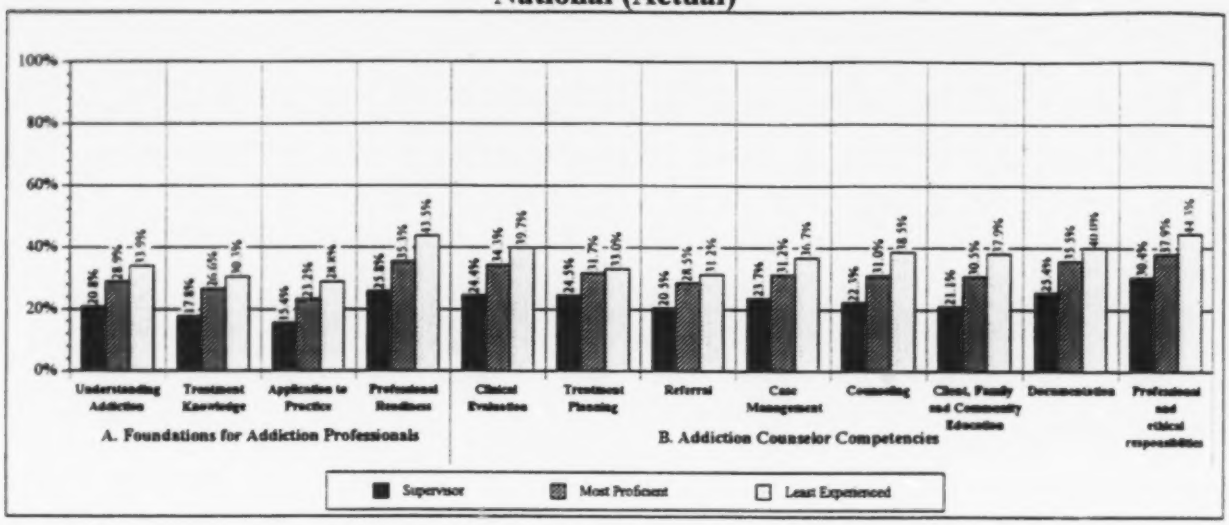
Table 6. ADDICTIONS CERTIFICATION

	Supervisor	Most Proficient	Least Experienced	Total
ADDICTIONS CERTIFICATION				
Yes	308	264	156	728
No	144	141	209	494
Total	**452**	**405**	**365**	**1222**
missing	n=30 (2.4%)			

Note: From Entry Level Addiction Counselor Competency Survey: National Results, by R. J. Adam and S. L. Gallon, 1997, Portland, OR: Northwest Regional Educational Laboratory.

Northwest Frontier Addiction Technology Transfer Center
Needs Assessment 1997

National (Actual)



National (Needed)

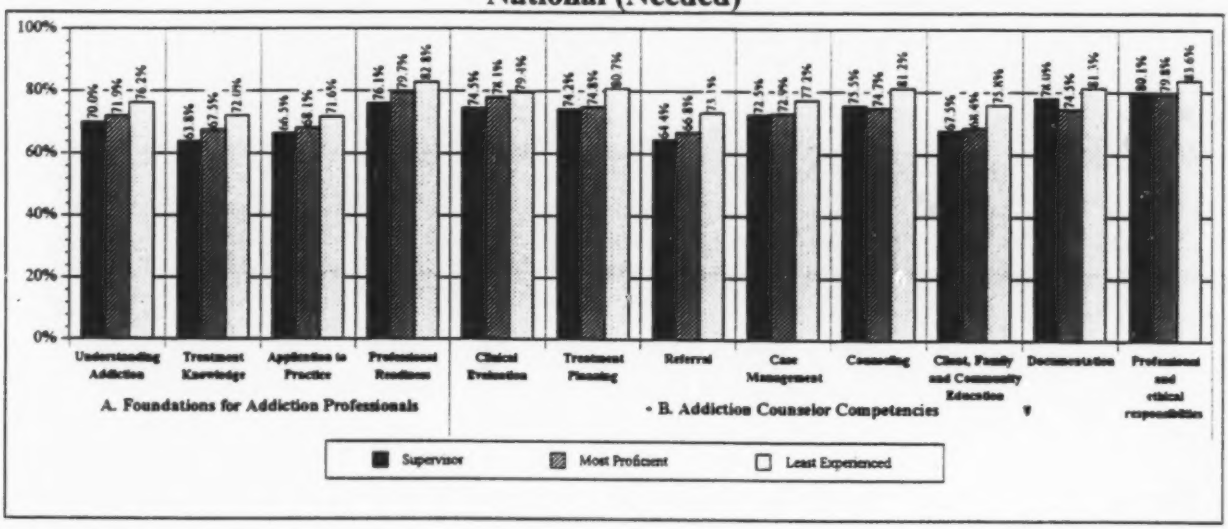


Table 7

Note: From Entry Level Addiction Counselor Competency Survey: National Results, by R. J. Adam and S. L. Gallon, 1997, Portland, OR: Northwest Regional Educational Laboratory.

CSAT Addiction Technology Transfer Centers
Entry-Level Addiction Counselor Competencies Needs Survey 1997

NATIONAL

Percentage Gap between Actual and Needed Level as Perceived by Supervisors

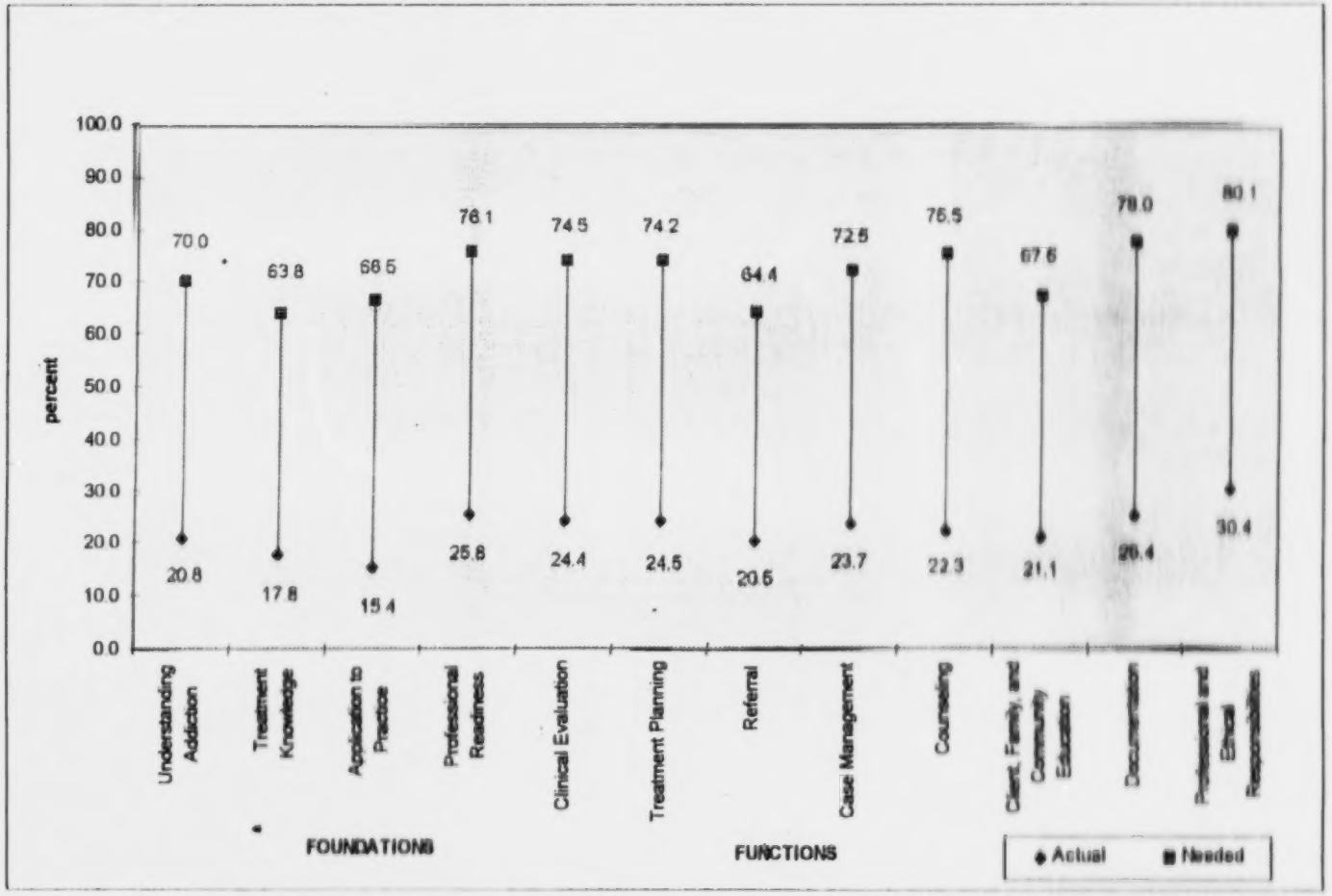


Table 8

Note: From Entry Level Addiction Counselor Competency Survey: National Results, by R. J. Adam and S. L. Gallon, 1997, Portland, OR: Northwest Regional Educational Laboratory.

Appendix A

Addiction Counselor Competencies

Curriculum Review Committee
Addiction Training Center Program

Sponsored by the
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

September 1995

Curriculum Review Committee
Addiction Training Center Program
Center for Substance Abuse Treatment

Addiction Counselor Competencies

Introduction

This document was developed by the Curriculum Review Committee of the federally funded Addiction Training Center Program. The purpose of the document is to describe the knowledge, skills, and attitudes that characterize competent practice in addictions counseling.

What knowledge, skills, and attitudes are essential to the competent practice of the profession of Addictions Counseling? Clearly, this professional field will be characterized by significant change in the coming decades. No one can predict in great detail the specifics of each counselor's setting, clientele, and practice. Nevertheless, we can predict with certainty that addictions counselors of the future will be individuals who are comfortable with the process of lifelong learning, who are able to apply their skills in a variety of settings, and who welcome the opportunity to develop new strategies in response to the changing needs of their clients and communities.

The content of this document represents our view of the competencies that appear to be necessary, at this point in time, for effective practice. We believe that the competencies described are applicable to a wide variety of settings across the continuum of care. We also believe that all addiction counselors should exhibit the competencies described here, and that training programs should try to ensure that these competencies are met. This material does not represent a training sequence or curriculum; rather it provides a description of training outcomes that can be achieved through a variety of educational strategies.

Organization of the Report

The knowledge and attitudes that form the basis of competent care across all health care disciplines are included in the section on Foundations for Addiction Professionals. The competencies that comprise the work of the addiction counselor are divided among eight primary functions under Addiction Counselor Competencies. Future reports will provide comparable competency descriptions for other addiction-related professions.

Nature of the Committee

The committee responsible for this document includes representatives from the network of Addiction Training Centers (ATCs) and the Center for Substance Abuse Treatment. The content represents a consensus that emerged from an intense collaboration over the course of a year. We recognize that the ideas contained here will change over time, and we plan to modify or add to the document as appropriate.

The committee wishes to thank Jerome H. Jaffe, M.D., Director, Office of Scientific Analysis and Evaluation, Edward T. Morgan, ATC Program Manager, and Nancy Kilpatrick, ATC Program Officer, for their ongoing support of the project.

Inquiries may be directed to the committee chair: *David A. Deitch, Ph.D., California Addiction Training Center, 9500 Gilman Drive, Department 0980, La Jolla, California 92093-0980.*

COMMITTEE MEMBERS

David A. Deitch, Ph.D
University of California / San Diego, La Jolla, California

Nereida Diaz, MA
Universidad Central del Caribe, Bayamon, Puerto Rico

Catherine E. Dube, Ph.D.
Center for Alcohol and Addiction Studies, Brown University, Providence, Rhode Island

Linda Foley, MA
Project for Addiction Counselor Training, Washington, D.C

Steven L. Gallon, Ph.D.
Office of Alcohol and Drug Abuse Programs, Salem, Oregon

Paula K. Horvatich, Ph.D.
Virginia Commonwealth University, Richmond, Virginia

Judy Lewis, Ph.D.
Governors State University, University Park, Illinois

Alan M. Parsons, ACSW
State University of New York, Albany, New York

Rafaela R. Robles, Ed.D
Universidad Central del Caribe, Bayamon, Puerto Rico

Susanne R. Rohrer, MBA, RN
Center for Substance Abuse Treatment, Washington, D.C.

Kevin R. Scheel, MS, LCDC
Commission on Alcohol and Drug Abuse, Austin, Texas

Susan A. Storti, RN, MA, CAS
Center for Alcohol and Addiction Studies, Brown University, Providence, Rhode Island

Earl Suttle, MS
Morehouse School of Medicine, Atlanta, Georgia

FOUNDATIONS FOR ADDICTION PROFESSIONALS

The following knowledge and attitudes are *prerequisite* to the development of competency in the professional treatment of addictions and other substance-related disorders. Such knowledge and attitudes form the base of understanding upon which discipline-specific proficiencies are built.

UNDERSTANDING ADDICTION

The professional is able to:

- Understand a variety of models and theories of addiction and other substance-related problems.
- Appreciate the social, political, economic, and cultural context within which addiction and substance abuse exist, including risk and resiliency factors that characterize individuals and their living environments.
- Describe the behavioral, psychological, physical health, and social effects of psychoactive drugs, including alcohol and tobacco, on the consumer and significant others.
- Recognize the potential for substance use disorders to mimic a variety of medical and psychological disorders, and the potential for medical and psychological disorders to co-exist with addiction and substance abuse.

TREATMENT KNOWLEDGE

The professional is able to:

- Describe the philosophies, practices, policies, and outcomes of the most generally accepted models of treatment, recovery, relapse prevention and continuing care for addiction and other substance-related problems.
- Appreciate the importance of family, social networks, and community systems in the treatment and recovery process.
- Understand the importance of research and outcome data, and their application in clinical practice.
- Appreciate the value of an interdisciplinary approach to addiction treatment.

APPLICATION TO PRACTICE

The professional is able to:

- Understand the established diagnostic criteria for substance dependence and abuse, and describe treatment modalities and placement criteria within the continuum of care.
- Describe a variety of helping strategies for reducing the negative effects of substance abuse and dependency.
- Tailor helping strategies and treatment modalities to the client's stage of dependency, change, or recovery.
- Adapt treatment services to the client's level of cultural and language literacy, acculturation, or assimilation.
- Appreciate the need to adapt practice to the range of treatment settings and modalities.
- Be familiar with medical and pharmaceutical resources in the treatment of addictive disease and other substance-related disorders.
- Understand the variety of insurance and health maintenance options available, and appreciate the importance of helping clients access those benefits.
- Recognize that crisis may indicate an underlying substance abuse problem, and may represent a window of opportunity for change.
- Understand the need for, and the use of, methods for measuring treatment outcome.

PROFESSIONAL READINESS

The professional is able to:

- Understand diverse racial and ethnic cultures, including their distinct patterns of interpreting reality, world view, adaptation, and communication, and to incorporate the special needs of minority groups and the differently abled into clinical practice.
- Understand the importance of self-awareness in one's personal, professional, and cultural life.
- Understand the addiction professional's obligation to adhere to generally accepted ethical and behavioral standards of conduct in the helping relationship.
- Understand the importance of ongoing supervision and continuing education in the delivery of client services.
- Understand the obligation of the addiction professional to participate in prevention, as well as treatment.
- Understand and appropriately apply agency-specific policies and procedures for handling crises or dangerous situations, including safety measures for clients and staff.

ADDICTION COUNSELOR FUNCTIONS

The basic tasks and responsibilities that constitute the work of an addiction counselor.

1. **Clinical Evaluation**
   - SCREENING
   - ASSESSMENT
2. **Treatment Planning**
3. **Referral**
4. **Case Management**
   - IMPLEMENTING THE TREATMENT PLAN
   - CONSULTING
   - CONTINUING ASSESSMENT AND TREATMENT PLANNING
5. **Counseling**
   - INDIVIDUAL COUNSELING
   - GROUP COUNSELING
   - COUNSELING FOR FAMILIES, COUPLES, AND INTIMATE DYADS
6. **Client, Family, and Community Education**
7. **Documentation**
8. **Professional and Ethical Responsibilities**

ADDICTION COUNSELOR COMPETENCIES

The knowledge, skills, and attitudes within each function that are essential to the competent practice of addiction treatment and substance abuse counseling.

1. Clinical Evaluation

The systematic approach to screening and assessment.

• SCREENING

The process through which the counselor, client, and available significant others determine the most appropriate initial course of action, given the client's needs, characteristics, and available resources within the community.

The counselor is able to:

- Establish rapport, including management of crisis situations and determination of need for additional professional assistance.
- Gather data systematically from the client and other available collateral sources, using screening instruments and other methods that are sensitive to age, culture and gender. At a minimum, data should include: current and historic substance use; health, mental health, and substance-related treatment history; mental status; and current social, environmental, and/or economic constraints on the client's ability to follow-through successfully with an action plan.
- Screen for alcohol and other drug toxicity, withdrawal symptoms, aggression or danger to others, and potential for self-inflicted harm or suicide.
- Help the client identify the role of substance use in his/her current life problems.
- Determine the client's readiness for treatment/change and the needs of others involved in the current situation.
- Review the treatment options relevant to the client's needs, characteristics, and goals.
- Apply accepted criteria for diagnosis, and the use of modalities on the continuum of care, in making treatment recommendations.
- Construct with the client and others, as appropriate, an initial action plan based on needs, preferences, and available resources.
- Based on an initial action plan, take specific steps to initiate an admission or referral, and ensure follow-through.

• ASSESSMENT

An ongoing process through which the counselor collaborates with the client, and others, to gather and interpret information necessary for planning treatment and evaluating client progress.

The counselor is able to:

- Select and use comprehensive assessment instruments that are sensitive to age, gender and culture, and which address:
  - History of alcohol and other drug use
  - Health, mental health, and substance-related treatment history
  - History of sexual abuse or other physical, emotional, and verbal abuse, and/or other significant trauma
  - Family issues
  - Work history and career issues
  - Psychological, emotional, and world-view concerns
  - Physical and mental health status
  - Acculturation, assimilation, and cultural identification(s)
  - Education and basic life skills
  - Socio-economic characteristics, lifestyle, and current legal status
  - Use of community resources
  - Behavioral indicators of problems in the domains listed above
- Analyze and interpret the data to determine treatment recommendations.
- Seek appropriate supervision and consultation.
- Document assessment findings and treatment recommendations.

2. Treatment Planning

A collaborative process through which the counselor and client develop desired treatment outcomes, and identify the strategies to achieve them.

At a minimum, the treatment plan addresses the identified substance-related disorder(s), as well as issues related to treatment progress, including relationships with family/friends, employment, education, spirituality, health concerns, and legal needs.

The counselor is able to:

- Obtain and interpret all relevant assessment information.
- Explain assessment findings to the client and others potentially involved in treatment.
- Provide the client and significant others with clarification and further information, as needed.
- Examine treatment implications in collaboration with the client and significant others.
- Confirm the readiness of the client and significant others to participate in treatment.
- Prioritize client needs in the order they will be addressed.
- Formulate mutually agreed-upon treatment outcomes for each need.
- Identify appropriate strategies for each outcome.
- Match treatment activities and community resources with prioritized client needs, in a manner consistent with the client's diagnosis and existing placement criteria.
- Develop, with the client, a mutually acceptable plan of action, as well as methods for monitoring and evaluating progress.
- Inform the client of his/her confidentiality rights, program procedures that safeguard them, and the exceptions imposed by statute.
- Reassess the treatment plan at regular intervals, and/or when indicated by changing circumstances.

3. **Referral**

The process of facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical evaluation and/or treatment planning.

The counselor is able to:

- Establish and maintain professional relations with civic groups, agencies, other professionals, governmental entities, and the community-at-large in order to ensure appropriate referrals, identify service gaps, expand community resources, and help address unmet needs.
- Continuously assess and evaluate referral resources to determine their appropriateness.
- Differentiate between situations in which it is most appropriate for the client to self-refer to a resource, and instances requiring counselor referral.
- Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs.
- Explain in clear and specific language the necessity for, and process of, referral to increase the likelihood of client understanding and follow-through.
- Exchange relevant information with the agency/professional to whom the referral is being made, in a manner consistent with confidentiality regulations and generally accepted professional standards of care.
- Evaluate the outcome of the referral.

4. Case Management

The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan.

Case management establishes a framework for action to achieve specified goals. It involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed care systems, and ongoing evaluation of treatment progress and client needs.

• IMPLEMENTING THE TREATMENT PLAN

The counselor is able to:

- Initiate collaboration with referral sources.
- Obtain and interpret all relevant screening, assessment, and initial treatment planning information.
- Confirm the client's eligibility for admission and continued readiness for treatment/change.
- Complete necessary administrative procedures for admission to treatment.
- Establish accurate treatment expectations for the client and involved significant others, including:
  - Nature of services
  - Program goals
  - Program procedures
  - Rules regarding client conduct
  - Schedule of treatment activities
  - Costs of treatment
  - Factors affecting duration of care
  - Client rights and responsibilities
- Coordinate all treatment activities with services provided to the client by other resources.

- **CONSULTING**

The counselor is able to:

- Summarize the client's background, treatment plan, recovery progress, and problems inhibiting progress for the purpose of assuring quality of care, gaining feedback, and planning changes in the course of treatment.
- Understand terminology, procedures, and the roles of other disciplines related to the treatment of addiction.
- Contribute as a member of a multi-disciplinary treatment team.
- Apply confidentiality-related legal restrictions appropriately.
- Demonstrate respect and nonjudgmental attitudes toward the client in all contacts with other professionals or agencies.

- **CONTINUING ASSESSMENT AND TREATMENT PLANNING**

The counselor is able to:

- Maintain ongoing contact with the client, and involved significant others, to ensure adherence to the treatment plan.
- Understand and recognize culturally appropriate stages of change and other signs of treatment progress.
- Assess treatment/recovery progress and, in consultation with the client and significant others, make appropriate changes to the treatment plan to ensure progress toward treatment objectives.
- Describe and document treatment process, progress, and outcome.
- Apply generally accepted measures of treatment outcome.
- Utilize referral skills, as described in Section 3 (above).
- Conduct continuing care, relapse prevention, and discharge planning with the client and involved significant others.
- Assure the accurate documentation of case management activities throughout the course of treatment.
- Apply placement, continued stay, and discharge criteria for each modality on the continuum of care.

5. Counseling

A collaborative process that facilitates the client's progress toward mutually determined treatment goals and objectives. Counseling includes individual, couple, family, and group methods that are sensitive to individual client characteristics and the influence of significant others, as well as the client's cultural and social context. Competence in counseling is built upon an understanding and appreciation of, and the ability to use appropriately, the contributions of various addiction counseling models as they apply to modalities of care for individuals, groups, families, couples, and intimate dyads.

• INDIVIDUAL COUNSELING

The counselor is able to:

- Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness and empathy.
- Facilitate the client's engagement in the treatment/recovery process.
- Work with the client to establish realistic, achievable goals consistent with achieving and maintaining recovery.
- Encourage and reinforce all client actions that are determined to be beneficial in progressing toward treatment goals.
- Work appropriately with the client to recognize and discourage all behaviors inconsistent with progress toward treatment goals.
- Recognize how, when, and why to use the client's significant others to enhance or support the treatment plan.
- Promote client knowledge, skills, and attitudes that contribute to a positive change in substance use behaviors.
- Promote client knowledge, skills, and attitudes consistent with the maintenance of good health (as defined by both the client culture and the treatment culture) and the prevention of HIV/AIDS, TB, STDs, and other communicable diseases.
- Facilitate the development of basic and life skills associated with recovery.
- Adapt counseling strategies to the individual characteristics of the client, including (but not limited to): disability, gender, sexual orientation, developmental level, acculturation, ethnicity, age, and health status.
- Make constructive therapeutic responses when the client's behavior is inconsistent with stated recovery goals.
- Apply crisis management skills.
- Mentor the client's identification, selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining treatment progress, relapse prevention, and continuing care.

• GROUP COUNSELING

The counselor is able to:

- Describe, select, and appropriately use strategies from accepted and culturally appropriate models for group counseling with addicted or substance abusing clients.
- Perform the actions necessary to start a group, including: determining group type, purpose, size, and leadership; recruiting and selecting members; establishing group goals and clarifying behavioral ground rules for participating; identifying outcomes; and determining criteria and methods for termination or graduation from the group.
- Facilitate the entry of new members and the transition of exiting members.
- Facilitate group growth within the established ground rules, and precipitate movement toward group and individual goals by using methods consistent with group type.
- Understand the concepts of "process" and "content," and shift the focus of the group when such an intervention will help the group move toward its goals.
- Describe and summarize client behavior within the group for the purpose of documenting the client's progress and identifying needs/issues that may require modification of the treatment plan.

• COUNSELING FOR FAMILIES, COUPLES, AND INTIMATE DYADS

The counselor is able to:

- Understand the characteristics and dynamics of families, couples, and intimate dyads affected by addiction.
- Be familiar with and appropriately use models of diagnosis and intervention for families, couples, and intimate dyads, including extended, kinship, or tribal family structures.
- Facilitate the engagement of selected members of the family, couple, or intimate dyad in the treatment and recovery process.
- Help members of the family, couple, or intimate dyad understand the interaction between their system and addiction.
- Help families, couples, and intimate dyads adopt strategies and behaviors that sustain recovery and maintain healthy relationships.

BEST COPY AVAILABLE

6. Client, Family, and Community Education

The process of providing clients, families, significant others, and community groups with information on risks related to alcohol and other drug use, as well as available prevention, treatment, and recovery resources.

The counselor is able to:

- Design and provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and/or the recovery process.
- Describe factors that increase the likelihood that an individual, community, or group will be at-risk for alcohol and other drug problems.
- Sensitize others to issues of cultural identity, ethnic background, age, and gender role or identity in prevention, treatment, and recovery.
- Describe warning signs, symptoms, and the course of addictions.
- Describe how addiction affects families and significant/concerned others.
- Describe continuum of care resources that are available to significant/concerned others.
- Describe principles and philosophies of prevention, treatment, relapse, and recovery.
- Understand the health and behavioral problems related to the treatment of addiction, including transmission and prevention of HIV/AIDS, TB, STDs, and other communicable diseases.
- Teach basic life skills such as stress management, relaxation, communication, assertiveness, and refusal skills.

7. Documentation

The recording of the screening and intake process, assessment, and treatment plan, as well as the preparation of written reports, clinical progress notes, discharge summaries and other client-related data.

The counselor is able to:

- Demonstrate knowledge of accepted principles of client record management.
- Protect client rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties.
- Prepare accurate and concise screening, intake, and assessment reports.
- Prepare and record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules.
- Record progress of the client in relation to treatment goals and objectives.
- Prepare an accurate, concise, informative, and current discharge summary.
- Document the treatment outcome, using accepted methods and instruments.

8. Professional and Ethical Responsibilities

The obligations of an addiction counselor to adhere to generally accepted ethical and behavioral standards of conduct and continuing professional development.

The counselor shall:

- Demonstrate ethical behaviors by adhering to established professional codes of ethics that define the professional context within which the counselor works, in order to maintain professional standards and safeguard the client.
- Adhere to federal and state laws, and agency regulations, regarding addictions treatment.
- Interpret and apply information from current counseling and addictions research literature in order to improve client care and enhance professional growth.
- Recognize the importance of individual differences by gaining knowledge about personality, cultures, lifestyles, and other factors influencing client behavior, and applying this knowledge to practice.
- Utilize a range of supervisory options to process personal feelings and concerns about clients.
- Conduct culturally appropriate self-evaluations of professional performance, applying ethical, legal, and professional standards to enhance self-awareness and performance.
- Obtain appropriate continuing professional education.
- Assess and participate in regular supervision and consultation sessions.
- Develop and utilize strategies to maintain physical and mental health.

References

Birch & Davis Corporation, *Development of Model Professional Standards for Counselor Credentialing.* Dubuque, Iowa: Kendall/Hunt Publishing (1986).

Institute for Chemical Dependency Professionals of Minnesota, *Counselor Core Functions.*

Project for Addiction Counselor Training, *Internship/Counselor Workbook.* Windsor, Connecticut (1991).

National Association of Alcoholism and Drug Abuse Counselors, *Development of Model Professional Standards for Counselor Credentialing.* Arlington, Virginia (1986).

National Certification Reciprocity Consortium/Alcohol and Other Drug Abuse, *Role Delineation Study for Alcohol and Other Drug Abuse Counselors.* Raleigh, North Carolina (1991).

Produced by the
Professional Development Program
Rockefeller College
University at Albany, State University of New York